THE MEDICAL ORGANIZATION OF SICKNESS INSURANCE.

BY

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BOSTON, MASS.

Director of the Boston Dispensary.

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THE remarkable Report of the Judicial Council of the American Medical Association, presented last June at the San Francisco session of that body, is timely and important at a moment when much consideration is being given to extensions of the insurance idea as measures of public welfare. "In pursuit of its functions to investigate general professional conditions," says the Report, "the Judicial Council considers it a duty to bring before the Fellowship of the American Medical Association a report of certain economic conditions that are arising in this country." [1]

"Some form of workmen's compensation law has been already passed in more than half the States of the Union, and there is small doubt that before long such laws will have been passed in the majority of the States if not in every one. The passing of these laws does not mean that some new or special law has been passed to compensate an injured workman under the old common law system, but it means an entirely new legal and social conception of compensation for injury and is, in fact, the beginning of a new social and economic condition in this country. These new economic conditions affect very materially the medical men in a community.

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It is certain to bring up the questions in new forms of contract and lodge practice, of health and accident insurance, of State aid and State medicine. It will also affect the relationship between the boards of trustees and the attending physicians and surgeons in private and municipal hospitals. Economic changes such as these must be of concern to the general profession, and the Judicial Council feels that it is timely to describe in general what these workmen's compensation laws are and what are their social and philosophic foundations, and what the trend at present seems to be in their relation to the profession."

Following this introduction, the Council's Report surveys briefly the steps taken by practically all the countries of Western Europe in providing compensation for industrial accidents, insurance against sickness, old age, maternity, etc. The Report points out that while the United States has been the last of the great nations to enter this field, the movement, once started here, has been rapid, no less than thirty-three States having adopted workmen's compensation laws within the past five years. In most countries such laws, providing for compensation for industrial accidents, have been the first step, preceding the establishing of sickness insurance. The Council refers to the probability that State laws for sickness insurance will be presented to various legislatures within the next few years. "In the near future," says the Report, "the majority of medical men in this country must face a new social condition in connection with the laws of workmen's compensation in accident and probably in sickness."

"Once the old social and legal equilibrium has been upset, society tends to follow to the logical conclusion until it reaches a new equilibrium under a new social system. We have in this country a disjointed mass of insurance schemes and pensions represented by life insurance, fraternal societies, so-called industrial insurance, which is in this country but burial insurance, and health and casualty insurance. There is the huge pen-

sion fund of the United States, which has really become the old age pension of those who fought on the Northern side in the Civil War. There are various industrial pensions for invalidity and old age, as in certain railroads or in certain large industrial establishments. In several large cities in the Union there is a rapidly growing expansion and extension of activities in the health board which constitutes State medicine.

"All these, at present, form an unrelated mass, all tending to give social aid in time of varying needs, to different members of the community. In several countries abroad the same various social elements have been combined into some form of workable adaptability by which various accident and sickness insurance, invalidity and old age pensions have been brought together to form social forces which have tended to reduce the destitution of large masses of human beings. These forces unquestionably tend to improve the social condition in any given community; and for the carrying out of any scheme tending to human betterment, the medical profession must necessarily be included, whether it be to judge of sickness or health insurance, whether it be for the prevention of the intensity of injury in the individual from accident, or for the prevention of the spread of disease in the community at large."

These far-sighted leaders of the medical profession thus look forward, like many laymen, to adaptations in existing medical service to meet new social conditions. Since a bill establishing sickness insurance will be introduced into the New York Legislature in 1916, and since more than one other State will doubtless experiment with sickness insurance within the next few years, it may be of interest to consider points in which the United States may possibly avoid some difficulties which foreign countries have experienced in dealing with the medical organization of sickness insurance.

In 1911, Great Britain adopted the most comprehensive system of sickness insurance yet extant. The act came into operation on July 15, 1912. It

was aimed, as the official statement says, "to provide for insurance against loss of health and for the prevention and cure of sickness and for insurance against unemployment." The emphasis upon prevention is significant. An official summary says:

"Insurance against ill-health is compulsory under the National Insurance Act for all employed persons who were sixteen or over, and under seventy, on the 15th July, 1912, and whose rate of remuneration is not over £160 a year; and all persons (within these age limits) employed by way of manual labor must be insured whatever may be their rate of remuneration. . . . The number of persons thus insured in the United Kingdom is nearly 14,000,000, and since the Act also affects their dependants, it may be said to influence either directly or indirectly the health of three-quarters of the whole population.

"The contributions in return for which insured persons receive benefits under the Act are payable jointly by employers, insured persons, and the State, the amounts ordinarily due being weekly sums of threepence from the employer, and fourpence from insured men and threepence from insured women; the State contributing two-ninths in the case of men and one-fourth in the case of women, of the cost of benefits and their local administration, as well as bearing the whole cost of central administration."

The collection of contributions, a huge task when millions of persons are involved, is made simple by the use of insurance stamps which are affixed to contribution cards at the time of the payment of wages. The stamps are purchasable at all post offices and the employers of insured persons must put them on the cards at the proper intervals and to the right amount. The employer pays the whole amount of the contributions in the first instance, but recovers from the employee the latter's share by deducting this from his wages. Persons must ordinarily obtain insurance through the Friendly Societies, which correspond, in a general way, to the fraternal orders in this country.

In return for the insurance payments, the benefits provided for the working men and women are as follows:

1. *Medical Benefit.* Treatment in illness by a qualified medical practitioner and necessary medicines and appliances.

2. *Sickness Benefit.* Weekly cash payments of 10s. for men and 7s. 6d. for women, for a period not exceeding twenty-six weeks. The payment begins on the fourth day of an illness which incapacitates the person from working. If the insured person remains incapacitated at the end of the twenty-six weeks, a disablement benefit of not over 5s. a week is allowed.

3. *Maternity Benefit.* The payment of a sum of 30s. on the confinement of insured women or the wives of insured men.

4. *Sanatorium Benefit,* providing for care of cases of tuberculosis.

In Germany, which began with compulsory sickness insurance in 1883, the administration of the system is supervised by the State, but is left primarily in the hands of local societies, chiefly organizations formed along occupational or industrial lines. The employee contributes two-thirds, the employer one-third of the payments. Medical care is provided, and the sick benefits are based on one-half the average wages of the class of employees to which the person belongs.

In the United States there has been an enormous development of so-called "industrial" insurance, now reaching some fifteen million policy-holders in private companies. This is practically nothing but burial insurance, providing, at high cost to the insured, a fund for funeral expenses. Insurance against sickness has appeared under private auspices in a few industrial establishments. In-

valid pensions and old-age pensions have been worked out in some large industries, notably certain railroads. Fraternal societies have provided for a certain proportion of the working population the questionable lodge doctor. The only satisfying and striking development in the United States, as the Report of the Judicial Council says, has been the sweep of workmen's compensation laws, or accident insurance, which has spread into two-thirds of the States of the Union within the past five years. Except for this, social insurance is in its infancy in this country. Its future lies ahead; and in planning for this future Americans may well observe and profit by the experience of other countries.

The point of greatest difficulty in Germany and England has been the organization of the medical service for the sickness insurance. In both countries there have been severe conflicts between the insurance organization and the medical societies. In Great Britain, at the commencement of the war, there were, however, fully nine-tenths of the 22,000 physicians of the country on the insurance "panels" —that is, these 20,000 physicians were accepting insurance cases in their several districts. The doctor is ordinarily paid on the basis of so much per year for each person on his "panel." Allowance is made in addition for provision of medicines and appliances. The patient is free to select his physician from the "panel" of the district, subject of course to the consent of the doctor to act.

The financial outcome for the medical profession has been excellent. During the eighteen months following the initiation of the National Insurance Act, the payments to British physicians under the Act amounted to $20,500,000. This was an average of $1,150 for each physician on the

"panels." The average payment per visit has worked out to be about one dollar. The average cost per patient per year for medical service for the first eighteen months was about $1.87. "It is claimed," declares the Report of the Judicial Council," "that the insurance act has raised the level of remuneration in the profession, that the average income of physicians has been increased by from $750 to $2,000 a year. It seems to be the general opinion that individual physicians may have suffered and received less remuneration under this act than they formerly received under some special form of contract work; but the general amount of moneys paid to the physicians working among the industrial classes has greatly increased, and the average income of the physicians has evidently much increased."

What of the effects of the Insurance Act on the people? Previous to its passage, the situation was like that which now exists in this country. Millions of people have either no medical attendance at all or secure it only in grave emergencies. Such was the situation in Great Britain. The Insurance Act worked a revolution by making medical service accessible to the whole working population. The well-to-do classes have not, of course, been especially affected by the Act, nor have those physicians and specialists in the large cities, whose practice has been among the well-to-do.

The Act has vastly extended the reach of medical practice. It has not greatly affected the medical organization of practice, and this is its substantial defect from the standpoint of medical efficiency. The German system has been no better in this respect. Neither system has recognized the profound change which the advance of medical science has brought upon medical service. Exact laboratory

methods of diagnosing many diseases have been substituted for guess-work. The applications of bacteriology, physiology and chemistry have revolutionized methods of diagnosis, treatment and prevention. The field of medical knowledge and the technique of practice in medicine and surgery, have become far too large and too complicated to be mastered by any one man. Specialists in a great variety of medical branches have been created. The general practitioner has largely lost his place in the medical service utilized by the well-to-do. For general illnesses the wealthy call in the internist, who may be a sub-specialist in lungs or in gastrointestinal disease; for operations the surgeon, and here again a choice may be made among men each of whom gives himself to the surgery of a particular region; for a confinement, the specialist in obstetrics is called; in eye or throat trouble the oculist or laryngologist; the babies and little children of the family are under the care of a man who treats only children. The orthopedist is sought when indicated, while the laboratory worker and the *x*-ray man are frequently called upon to aid many of the specialists. The members of a single fairly healthy family might call upon five or six different specialists in the course of six months, while for a single obscure disease, two to ten men might be utilized. Should the patient go into a hospital, the same would be true: a group of the specialists who compose the hospital staff would work together on his case. There is, however, one essential difference between the situation in the hospital and that outside. In private medical practice the inter-relations among the various specialists, and between them and the patient, are not organized, except through those mutual understandings between physicians which are crystallized in

certain sections of the code of medical ethics. In hospitals and dispensaries, on the other hand, these relations have been organized. Moreover, in private practice each physician has his independent equipment in his office, or depends for laboratory and x-ray work upon the offices of other men, who are remunerated for each case. In the hospital or dispensary there is organization of equipment as well as of personnel; duplication of instruments and apparatus is avoided, and each unit is put to the maximum use. It is, in fact, to the hospitals and dispensaries that we must turn to-day if we are to study medical service at its best.

The principle under which the medical organizations of the best general hospitals and dispensaries are organized is that of medical teamwork. In such varied institutions as the factory, the university and the hospital, we see exemplified the now familiar principle that specialization is necessary to the maximum of efficiency and that specialization requires organization if this end is to be achieved. The medical care of a patient includes two essential stages: the establishment of a diagnosis and the carrying out of treatment. In both stages the co-operation of specialists is important, but particularly in making the diagnosis. Even where the diagnosis is readily established, treatment often requires one who is especially expert in a particular service. When, as is not infrequently the case, several different specialists are needed for a single patient, their co-operation in working together is of the highest importance. Confusion in the mind of a patient in private practice today is not infrequent and the expense to the patient is enhanced by lack of organization.

The modern hospital is an institution for the organization of specialists for the care of patients

who are sick enough to be in bed. These specialists utilize equipment in common. A dispensary similarly is an organization of specialists for the treatment of patients whose diseases do not prevent them from going out to see the doctor, that is, ambulatory cases. The relation between the hospital and dispensary from this standpoint is essentially that between the practice of a private physician in the homes of his patients and at his office. A dispensary is essentially an organized system of office hours; a hospital, an organized system of caring for patients in bed.

The advances of medical science have enormously increased the technical equipment necessary for the diagnosis and care of disease. Merely mentioning modern requirements of laboratory and x-ray service, not to speak of operating facilities and instruments, is enough to illustrate the point. This elaborate equipment is beyond the reach of the individual physician, even those dealing with the well-to-do. The hospital or dispensary can provide equipment for the use of many. Through organization it saves the time which physicians and particularly specialists spend between the intervals of seeing patients. An organization such as the famous Mayo Clinic at Rochester, Minn., exemplifies a dispensary organization which has been most carefully worked out with the maximum of medical as well as business efficiency in mind. Seventy-five picked men constitute its medical staff. The organization of the whole clinic is designed to aid in establishing diagnoses of disease and in providing or supervising its treatment by organizing the teamwork of its specialists with a minimum expenditure of time and maximum utilization of scientific aids to medical work. It also minimizes through organization, the confusion to which con-

tact with a variety of specialists often leads in private practice among the well-to-do.

The same principles can be seen illustrated in the best dispensaries managed by charitable institutions and treating patients free or for nominal charges; and in the best hospitals giving care to bed cases.

Hospital service in America has developed enormously within recent years; dispensary service at an even faster pace. A million persons now receive treatment in hospital beds annually in the United States, and three million ambulatory cases are treated in dispensaries. The number of dispensaries has increased at least seven-fold in the last fifteen years. A report published in 1914 by a Committee of the American Hospital Association may be quoted:[5]

"In 1900 there were about 100 dispensaries in the United States, 80 to 90 of these being general dispensaries. The number increased, year by year, with considerable rapidity, so that, in 1904, the Census Bureau, which then made a survey, reported 156 institutions, the actual number, allowing for probable omissions, being toward 200. Most of these, again, were general dispensaries, the remainder being for diseases of special organs, chiefly eye, ear, nose and throat. The growth of general dispensaries has continued, as may be seen from the preceding figures, the number of these having multiplied four times since 1900 and two and a half times since 1904.

"One of the reasons for this growth has undoubtedly been the increasing demand of medical men for clinical material, both for experience and for teaching purposes. Another reason is the growing demand on the part of the public, particularly the part of the public receiving low wages, which, in the large cities, has been put under heavier and heavier pressure by the rising cost of living. A third and very important reason is the growing interest in public health, which has taken up the dispensary as an agent in its campaign. This has undoubtedly played some part in the development

of dispensaries treating general diseases. It has been the chief cause leading to the establishment of a very large number of out-patient clinics treating special diseases, particularly tuberculosis."

The justification of these references to the development of dispensaries and hospitals lies in the fact that until very recently this development, particularly that of dispensaries, has been little called to the attention of the public. The application to the problem of sickness insurance is not far to seek. If a system of sickness insurance is to provide medical service for a large part of the working population on the financial basis provided by insurance payments, surely the medical organization of the system ought to be in line with the most advanced forms of medical work; or at least the system should contemplate development in that direction. Neither the British system nor the German organizes the medical service beyond the stage of individualistic private practice. The British system has failed to utilize the important existing centres of medical organization provided in the larger cities by the hospitals and dispensaries. Before sickness insurance was established in Great Britain, three years ago, a great part of the population suffered from a lack of medical service. It is a great gain to have met this deficiency but much still lies ahead. America should build upon foreign experience and go Great Britain one better. The developing movement for sickness insurance in the United States should provide or look forward to the best form of medical organization.

Practical suggestions to this end must be considered. Conditions of medical service in smaller communities or in rural districts are so different from those in cities that it is unwise to expect uniformity of system throughout. Within the boun-

daries of a single State such as New York or Massachusetts, conditions vary over such a wide range that a state system of insurance ought to provide for local variations and be sufficiently flexible to admit of development as local communities themselves advance.

In the larger centres the existing facilities of the hospitals and dispensaries ought to be utilized by the sickness insurance system. The dispensary is of especial importance to sickness insurance because its special field is prevention. Serious diseases in their earlier stages, minor diseases which sap vitality or reduce working efficiency, serious but not incapacitating diseases such as syphilis, gonorrhea, various diseases of the throat and other special organs, are examples which fall within the special field of the dispensary. People need to come to the doctor earlier so they may be kept at work or at least be sent back to work with a minimum of lost time.

The task of organization here is a large one. Experiments are now in order to test out various methods, each of which may be applicable to one or another set of local conditions. For example:

In the German and in English sickness insurance systems, voluntary organizations (such as are known in this country as trade unions, fraternal orders or establishment funds including the employees of a particular company) are allowed to make their own insurance arrangements with medical men under the supervision of the State Insurance Department. Undoubtedly, under any sickness insurance plan adopted in America, such approved societies would be similarly recognized. Such societies should be allowed to make contracts for their medical services under the insurance system with a dispensary or hospital. The physicians who pro-

vide the medical service through the medium of the institutions should receive the same compensation as the physicians who work outside as individuals.

Time and money will be saved if the care of patients who do not require confinement in bed can be so organized that the patients come to the doctor instead of the doctor traveling to the homes of the patients. This means either at the offices of the doctors or at a central place, namely a dispensary, to which the ambulatory cases come. Enough has already been said in this paper on the advantage of so organizing the service that the material and personal equipment of the dispensary can be used for these ambulatory cases. Merely utilizing the individual practitioner and therefore requiring many visits at the homes for the treatment of ailments which do not confine the patient to the house, is not economical and is not the most efficient medically, even disregarding its extra expense. The utilization of a dispensary also provides for the services of a medical team of specialists, but it would be decidedly unfortunate to utilize the dispensary for such specialists' services only. Existing dispensaries should be adapted or new dispensaries established to meet the conditions of the insurance system.

A large part of the sickness insurance is necessarily carried by other than the voluntary societies previously referred to. In this country these groups will necessarily be local associations of the insured persons. Such local health associations may, like the approved societies, make arrangements with an existing dispensary and hospital, or with an organized group of doctors who might either start a dispensary or arrange to utilize the equipment of one already established. By organized group of physicians is meant a body of men who have so

selected themselves as to include a variety of medical interests or specialties, and who have agreed to work as a team rather than as individual practitioners.

Under the British and German insurance systems, persons above a certain grade of income are allowed to take sickness insurance as so-called "voluntary insurers," while all persons having less than a specified minimum income come under compulsory insurance and must join. Voluntary mutual insurance groups should be encouraged. The strongest encouragement, so far as sickness insurance is concerned, will be the possibility of securing high grade medical service at lower cost than would be possible without co-operation. Abroad, the voluntary insurers have been relatively few in number. In the United States there is a growing recognition of the difficulty with which the middle classes—professional men, small business men and moderately salaried positions of all kinds—can secure enough of the same kind of medical service which is now open to the rich and to the poor. By co-operation on the part of the patients, making up a volunteer insurance group, such a service could be financed; and by co-operation on the part of the physicians using the principle of medical teamwork and a joint diagnostic equipment, the service could be made medically efficient. If such an economic inducement can be offered to the middle classes, we may perhaps hope for the development of many voluntary health insurance groups.

To test out methods of medical service on the teamwork plan through such voluntary groups is of high importance. Either the equipment afforded by an existing hospital or dispensary, or that newly provided by a group of doctors associating themselves co-operatively, should be utilized. The former

would usually be the more economical plan, the latter might better fit localities where hospitals and dispensaries are poorly developed, and would meet the prejudice of those who have been accustomed to think of hospitals and dispensaries as only for "objects of charity."

In summary, the argument of this paper leads to the suggestion that a sickness insurance law should permit medical service on *either* the co-operative or the individualistic basis. The sickness insurance system should of course enable the present British plan to be followed of utilizing individual physicians (or the members of a district medical society) on a panel system, but as an alternative plan, it should also allow and encourage local societies or associations of the insured to make suitable arrangements for medical service with a dispensary or hospital, or if necessary, to establish such an institution. Only by utilizing a joint diagnostic and thereapeutic equipment, and the teamwork of a group of physicians, can the maximum service of modern medical science in the cure and prevention of diseases, be made financially accessible to the mass of the community.

REFERENCES.

1. *Journal of the American Medical Association,* July 3, 1915, LXV, p. 74.
2. *Op. cit.,* p. 91.
3. Report for 1912-13 on the Administration in England of the National Health Insurance Act, Part I, p. 1.
4. *Journal of the American Medical Association,* July 3, 1915, LXV, p. 74, p. 85.
5. Proceedings of the American Hospital Association, 1914, page 313.

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